

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 01704 1660

1. PLACE OF DEATH:

County GarrettCity or town Crellin, Maryland.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life time

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County GarrettCity or town Crellin, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Mrs. Sarah Elizabeth Adams.

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widow6.(b) Name of husband or wife P. J. Adams.Deceased

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) April 9th, 1865

8. AGE: Years Months Days It less than one day

811016

_____ hrs.

_____ min.

9. Birthplace Rowlesburg, W. Va.

(Town, county, and state)

10. Usual occupation House wife

11. Industry or business

12. Name Charles Jackson Roy.13. Birthplace Rowlesburg, W. Va.14. Maiden name Lavinia Mason.15. Birthplace Rowlesburg, W. Va.16. Informant Mr. Stanley Ashby.Address Crellin, Md.17. Burial Date thereof Feb. 27/47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Terra Alta Cemetery.Location Terra Alta, W. Va.18. Funeral director Emory D. Bolden.Address Oakland, Md.19. Feb. 27, 1947 Julia Rowan

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25th 1947, at 12.4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 19, 1946, to Dec. 15, 1946.and that I last saw her alive on Dec. 15, 1946.

Immediate cause of death _____ DURATION

Coronary Heart DiseaseDue to Arterio Sclerosis

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Andrew E. Howe M.D.Address Oakland, Md. Date signed 27 Feb 47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MAR 20 1947

BUREAU OF

2-38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

Reg. Dist. No. 01795 1670

1. PLACE OF DEATH:

County GarrettCity or town Table Rock, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland. County GarrettCity or town Table Rock, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Paul Leonard Dawson.

3. (b) Social Security Number

235-22-4787

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married.6.(b) Name of husband or wife Ruby Williams Dawson.6.(c) If alive, give age 47 years7. Birth date of deceased (mo., day, yr.) February 22d, 1896.8. AGE: Years 50 Months 11 Days 18 If less than one day _____ hrs. _____ min.9. Birthplace Mt. Lake Park, Md.
(Town, county, and state)10. Usual occupation Appraiser for G. I. Loan

11. Industry or business

12. Name Joseph L. Dawson.13. Birthplace Frostburg, Md.14. Maiden name Jessie Arnold.15. Birthplace Lonaconing, Md.16. Informant Joseph L. Dawson.Address Mt. Lake Park, Md.17. Burial Date thereof February 14/47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Oakland, Cemetery.Location Oakland, Maryland.18. Funeral director Emory W. BoldenAddress Oakland, Md.19. 2/18 Edna C. Shaffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

A.M.

20. DATE OF DEATH February 11th 1947 at 10:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 1945 to February 11, 1947and that I last saw him alive on January 30, 1947Immediate cause of death Heart disease DURATIONfibrillation & sudden death 5 minutes.myocardial ischemiaDue to OverexertionDue to Coronary & generalized 2 yrs.arteriosclerosis with anginalOther conditions symptoms and inter- 1 month.mittent claudication

(Include pregnancy within 3 months of death)

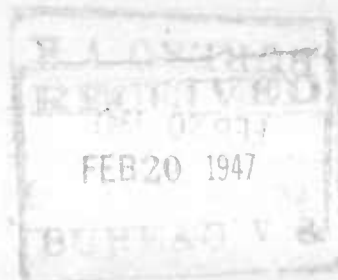
Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following (if)

Accident, suicide, or homicide Accident Date of 2/14/47Where did injury occur? Table Rock, Garrett Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) 11 a.m.Means of injury Shoveling snow Injured at work? yes23. SIGNATURE Harold C. Miller, M.D. M. D. or otherAddress Exlon, W. Va. Date signed 2/14/47



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 01706 1630

1. PLACE OF DEATH:

County Sanitt
 City or town Barton - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 yrs
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County Sanitt
 City or town Barton - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 321 West of Barton
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Alvin Fazenaker

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White married

6. (b) Name of husband or wife Mandy Fazenaker6. (c) If alive, give age 82 years7. Birth date of deceased (mo., day, yr.) June 17, 1864

8. AGE: Years 82 Months 7 Days 18 If less than one day
 hrs. min.

9. Birthplace Barton - Sanitt - Md.
 (Town, county, and state)

10. Usual occupation None11. Industry or business Stone mason12. Name Andrew J. Fazenaker13. Birthplace Maryland14. Maiden name Jane Fazenaker15. Birthplace Maryland16. Informant Robert FazenakerAddress Maryland - Md.17. Burial Date thereof Feb-19-1947

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetary or crematory Samuel Hill Cem.Location Maryland16. Funeral director E. H. Worth S. FrazeeAddress Westport Md.19. 2-21 19 47 Deputy Registrar

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH February 15 19 47 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

examined after death 19 47and that I last saw him alive on 19 47Immediate cause of death Coronary Occlusion

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. H. Worth S. Frazee Deputy RegistrarAddress Dakland Md Date signed 2/17/47

M. D. or other

FEDERAL BUREAU OF INVESTIGATION

Handwritten notes at the top of the page, including "The first" and "The second".

Handwritten notes in the middle section, including "The third" and "The fourth".

Handwritten notes below the middle section, including "The fifth" and "The sixth".

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FEB 24 1947
BUREAU OF INVESTIGATION

Handwritten notes at the bottom of the page, including "The seventh" and "The eighth".

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 1610

01707

1. PLACE OF DEATH:

County GARRETT
 City or town FRIENDSVILLE, MD. RURAL
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 yrs.
 Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Garrett
 City or town Friendsville, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. —
 (If rural, give LOCATION)
 2.(a) If veteran, name war —

3. (a) FULL NAME

HENRY W. FRIEND

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MALE WHITE MARRIED

6. (b) Name of husband or wife

PEARL FRIEND

7. Birth date of deceased (mo., day, yr.)

March 19 18836. (c) If alive, give age 55 years

8. AGE:

Years

Months

Days

If less than one day

631016— hrs. — min.

9. Birthplace

MD.
(Town, county, and state)

10. Usual occupation

FARMER

11. Industry or business

FARMING

MOTHER FATHER

12. Name

JOHN W. FRIEND

13. Birthplace

MD.

14. Maiden name

MARY MARKLEY

15. Birthplace

MD.

16. Informant

Mrs. Pearl Friend

Address

Friendsville, Md. Rural.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Feb. 9 1947
(month) (day) (year)

Cemetery or crematory

Blooming Rose Cemetery

Location

Friendsville Md., Rural.

18. Funeral director

W.H. Rodenhaver

Address

Markleysburg, Penna.

19.

(Date rec'd by registrar)

Feb 7 1947Kathryn Fike

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 5th 1947 at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 26, 1946, to FEB 5th 1947and that I last saw him alive on FEBRUARY 5th 1947

Immediate cause of death

Chronic Myocarditis

DURATION

2 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Milton Tepfer, M.D.

M. D. or other

Address

Friendsville Md.

Date signed

Feb 7 1947

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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FEB 26 1947

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 01798/700

1. PLACE OF DEATH: *Garrett Co.*
 County.....
 City or town.....*Near Lonaconing*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....*Life time*
 Hospital, institution, or street address where death occurred:

 How long to hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....*Maryland* County.....*Garrett*
 City or town.....*Near Lonaconing*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME
Elsie Ruth B. Green

3. (b) Social Security Number

4. Sex.....*Female* 5. Color or race.....*White* 6.(a) Single, married, widowed, or divorced.....*Married*

6.(b) Name of husband or wife.....*Richard Green*

7. Birth date of deceased (mo., day, yr.).....*July 9, 1900* 6.(c) If alive, give age.....*60* years

8. AGE: Years.....*46* Months.....*7* Days.....*17* If less than one day..... hrs. min.

9. Birthplace.....*Garrett Co.*
 (Town, county, and state)

10. Usual occupation.....*Housework*

11. Industry or business.....*Own home*

12. Name.....*Patten Broadwater*

13. Birthplace.....*Garrett Co.*

14. Maiden name.....*Ida B. Bittings*

15. Birthplace.....*Garrett Co.*

16. Informant.....*Mrs Ida B. Broadwater*

Address.....*Garrett Co., Near Lonaconing*

17. *Burial* (Burial, cremation, or removal. Which?) Date thereof.....*Feb 1, 1947*
 (month) (day) (year)

Cemetery or crematory.....*Garrett Hill Cemetery*

Location.....*Moscow, Md.*

18. Funeral director.....*M. Eichhorn*

Address.....*Lonaconing, Md.*

19. *Mar 1* 19 *47* *Jannette M. Boal*
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*Feb 25* 19 *47* at *6 P.* M

21. I CERTIFY that death occurred on the date above stated that I attended deceased from.....*Hummer Dyer died* 19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death.....*Chronic myocarditis*

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....Date of.....

Where did injury occur?.....(City or town).....(County).....(State).....

Injured at home, farm, industry, public place (where?).....

Means of injury.....Injured at work?

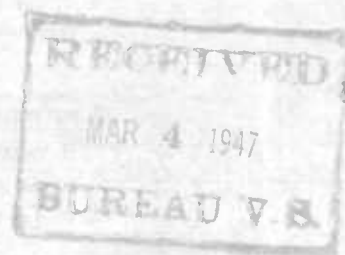
23. SIGNATURE.....*J. J. ...* M. D. or other

Address.....*Calverton* Date signed.....*2/26/47*

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (112)

CERTIFICATE OF DEATH

Reg. Dist. No.

01709

1660

1. PLACE OF DEATH:

County GarrettCity or town Rural Swanton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County GarrettCity or town Rural Swanton

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2 mi. North Swanton, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war -----

3. (a) FULL NAME

Mildred Hazel (Comp) Johnston

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female

White

Married

6. (b) Name of husband or wife Frank Johnston6. (c) If alive, give age 46 years7. Birth date of deceased (mo., day, yr.) March 4, 1912

8. AGE: Years Months Days If less than one day

34

11

13

-----hrs. -----min.

9. Birthplace Swanton; Garrett Co., Md.

(Town, county, and state)

10. Usual occupation House Wife11. Industry or business Own Home12. Name William Comp13. Birthplace Unknown14. Maiden name Alberta Upole15. Birthplace Unknown15. Informant Frank JohnstonAddress Swanton, Md.17. Burial Date thereof Feb. 19, 1947

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory George CemeteryLocation 1 mi. West Swanton, Md.18. Funeral director Herbert C. LeightonAddress Oakland, Maryland.19. 2/19/47 47 Julia Rawon

(Date rec'd by registrar)

19.

47

Julia Rawon

local

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16, 1947, at 8:45P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1 - 1946 to Feb 16, 1947and that I last saw him alive on Feb. 16, 1947Immediate cause of death BronchitisasthmaBronchiectasis

DURATION

10 yrs

5 yrs

Due to -----

Due to -----

Other conditions -----

(Include pregnancy within 3 months of death)

Major findings of operations -----

Date of op. -----

Autopsy results -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ----- Date of -----

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -----

Means of injury ----- Injured at work? -----

23. SIGNATURE P. E. Berry M. D. or otherAddress Piedmont, W. Va. Date signed 2/19/47

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MAR 6 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

Reg. Dist. No. 01719721

1. PLACE OF DEATH:
 County Garrett
 City or town Shallmar
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 yr.
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Garrett
 City or town Shallmar
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war World War 2

3. (a) FULL NAME John Lester Kenney

3. (b) Social Security Number 220-07-6401

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Gertrude (Martin) Kenney
 7. Birth date of deceased (mo., day, yr.) August 15, 1914 6. (c) If alive, give age 32 years
 8. AGE: Years 32 Months 5 Days 23 If less than one day _____ hrs. _____ min.

9. Birthplace Elk Garden, Mineral Co., W.Va.
 (Town, county, and state)
War Veteran

10. Usual occupation unemployed

11. Industry or business unemployed
 12. Name John Joseph Kenney
 13. Birthplace Elk Garden, W.Va.

14. Maiden name Sarah Ethel DeShong
 15. Birthplace Cross, Mineral, Co., W.Va.

16. Informant John J. Kenny
 Address Shallmar, Md.
Burial

17. (Burial, cremation, or removal, Which?) Date thereon Feb. 11, 1947
 (month) (day) (year)
 Cemetery or crematory Kalbaugh Cemetery
Elk Garden, W.Va.
 Location _____

18. Funeral director Otha F. Sharpless
 Address Blaine, W.Va.

19. 2/10 47 Al W. Barwick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8 19 47 at 10:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____ 19 _____
 and that I last saw him _____ alive on Dead in funeral 19 _____

Immediate cause of death _____ DURATION _____
Coronary Thrombosis
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE Ralph Calandrella M.D. M. D. or other _____
 Address Hitzmiller, Md. Date signed Feb. 8-47

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 01711 1660

1. PLACE OF DEATH:
County Garrett
City or town Mt. Lake Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, institution, or street address where death occurred:
Kiser Nursing home
How long in hospital or institution? 7 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Garrett
City or town Bloomington
(If outside city or town limits, write RURAL and give nearest town)
Street No. ---
(If rural, give LOCATION)
2.(d) If veteran, name war ---

3. (a) FULL NAME

Martin V. Kerns

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
6.(b) Name of husband or wife ---
6.(c) If alive, give age 2 years
7. Birth date of deceased (mo., day, yr.) not known, may be 1864
8. AGE: Years about 82 Months --- Days --- If less than one day --- hrs. --- min.
9. Birthplace Allegheny Co., Md.
(town, county, and state)
10. Usual occupation Laborer
11. Industry or business General
12. Name Unknown
13. Birthplace Unknown
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Mrs. Mary Kiser
Address Mt. Lake Park, Md.

17. Burial Date thereof Feb. 14, 1947
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Oakland Cemetery
Location Oakland, Maryland.
18. Funeral director Herbert P. Leighton
Address Oakland, Maryland.
19. 2/14/47 19. 47 Lelia A. Kiser
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 12, 1947, 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1943 19. 2-12-47 19. ---
and that I last saw him alive on 2-10-47 19. ---

Immediate cause of death Paralysis of Throat following Cerebral Hemorrhage DURATION 1 week
Due to ---
Due to ---
Other conditions Arteriosclerosis and Arthritis and Nephritis years ---
(Include pregnancy within 3 months of death)

Major findings of operations --- Date of op. ---

Autopsy results ---
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide --- Date of ---
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ---
Means of injury --- Injured at work? ---

23. SIGNATURE Herbert P. Leighton M. D. or other ---
Address Oakland, Maryland. Date signed 2-14-47

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 01712 1660

1. PLACE OF DEATH:

County Garrett
 City or town Near Oakland, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Garrett
 City or town Near Oakland, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Xavier Kreyenbuhl.

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widower
 6.(b) Name of husband or wife Christina Kreyenbuhl.
Deceased 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) October 11th, 1853
 8. AGE: Years 94 Months 4 Days 11 If less than one day _____ hrs. _____ min.

9. Birthplace Switzerland.
 (Town, county, and state)
 10. Usual occupation Retired Farmer
 11. Industry or business

MOTHER FATHER
 12. Name John Kreyenbuhl.
 13. Birthplace Switzerland.
 14. Maiden name Entenmann
 15. Birthplace Switzerland.

16. Informant Mr. Leo Kreyenbuhl.
 Address Deer Park, Md.

17. Burial Date thereof Feb/25/47
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory St. Peters Cemetery.
 Location Oakland, Maryland.

18. Funeral director Erroy D. Bolden
 Address Oakland, Md.

19. Feb 25 19 47 Julia A. Kreyenbuhl
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

A.M

20. DATE OF DEATH February 23d, 1947 at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1943 to Feb. 23 1947
 and that I last saw him alive on Feb. 20 1947

Immediate cause of death Chronic Myocarditis
 DURATION

Due to _____

Due to _____

Other conditions Acute Urinary Suppression 1 wk
 (Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE E. D. Bauninger M.D. M. D. of other _____Address Oakland Md Date signed 2/24/47

RECEIVED
MAR 6 1947
BUREAU 18

2-35

CERTIFICATE OF DEATH

Reg. Dist. No.

Address.....Baltimore, Maryland..... Date signed.....2-21-4.....

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 6 1947

BUREAU

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (S3-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 01714 1721

1. PLACE OF DEATH:
County Garrett
City or town Kitzmiller
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Garrett
City or town Kitzmiller
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME Roy Orlando Rafter

3. (b) Social Security Number
214-07-6087

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
8. (b) Name of husband or wife Margaret Alberta (Grimm) Rafter 6. (c) If alive, give age 70 years
7. Birth date of deceased (mo., day, yr.) October 5, 1873
8. AGE: Years 73 Months 4 Days 2 If less than one day _____ hrs. _____ min.

9. Birthplace Kitzmiller, Garrett Co., Md.
(Town, county, and state)
10. Usual occupation Retired- Machinist
11. Industry or business Celenses

12. Name John Henry Rafter
13. Birthplace Headsville, W.Va.
14. Maiden name Victoria Ellen Kitzmiller
15. Birthplace Kitzmiller, Md.

16. Informant Mrs. R.O. Rafter
Address Kitzmiller, Md.

Burial
17. (Burial, cremation, or removal. Which?) Date thereof Feb. 9, 1947
(month) (day) (year)
Cemetery or crematory Kitzmiller Cemetery
Location Kitzmiller, Md.

18. Funeral director Otha F. Sharpless
Address Blaine, W.Va.

19. 2/8 47 W. C. Burick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 7, 1947 at 8:55P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 30 1947 to Feb. 7 1947 and that I last saw him alive on Feb. 7-47 19

Immediate cause of death Cerebral hemorrhage in the left side

Due to hypertension

Other conditions _____
(Include pregnancy within 8 months of death)

Major findings of operations _____
Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work?

23. SIGNATURE Ralph Calanella M. D. or other _____
Address Kitzmiller, Md. Date signed Feb. 8-47

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FEB 20 1947

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *8d*

CERTIFICATE OF DEATH

Reg. Dist. No. *01715 17/0*

1. PLACE OF DEATH:

County *Garett*
City or town *Bitteringer Rural*
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? *9 Months*
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State *Maryland* County *Garett*
City or town *Rural Grantsville*
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Jennie Stanton

3. (b) Social Security Number

None

4. Sex *F* 5. Color or race *W* 6.(a) Single, married, widowed, or divorced *Single*

6. (b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *May 9. 1865*

8. AGE: Years *81* Months *9* Days *11* If less than one day
..... hrs. min.

9. Birthplace *Rural, Bitteringer, Garrett Md*
(Town, county, and state)

10. Usual occupation *None*

11. Industry or business

12. Name *Thomas Stanton*

13. Birthplace *Rural Near, Bitteringer Md*

14. Maiden name *Louise Broadwater*

15. Birthplace *R.D.2, Grantsville Md*

18. Informant *Martin Stanton*

Address *Bitteringer Md*

17. *Burial* Date thereof *2-24-1947*
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory *Bitteringer*

Location *Bitteringer Md*

18. Funeral director *Allen Winterberg*

Address *Grantsville Md*

19. *Feb. 24 1947*
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH *Feb 20 1947* at *10:00 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Examined after death
and that I last saw him alive on *19*

Immediate cause of death

Chronic myocarditis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address *Darland Md* Date signed *2/21/47*

MARGIN RESERVED FOR BINDING

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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FEB 27 1947

BUREAU V 8

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01716
166
Reg. Dist. No.

1. PLACE OF DEATH:

County Garrett
 City or town Oakland, Maryland.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life time.
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Garrett
 City or town Oakland, Maryland.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Paul LeRoy Stark.

3. (b) Social Security Number

215-14-6396

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Single.

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 16th, 1920.8. AGE: Years Months Days If less than one day
26 11 12 hrs. min.9. Birthplace Shellmar, Md.
(Town, county, and state)10. Usual occupation Truck Driver.

11. Industry or business

12. Name Henry Leonard Stark.13. Birthplace Bittinger, Md.14. Maiden name Lulu Stewart.15. Birthplace Pekins, Md.16. Informant Mrs. Lulu Stark.Address Oakland, Maryland.17. Burial Date thereof March 9/47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Oakland, Cemetery.Location Oakland, Maryland,18. Funeral director Eurus D. BolderAddress Oakland, Md.19. Mar. 8 19 47 Julius G. Hannon
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28 19 47 at 4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Examined after death 19 47and that I last saw him alive on 19 47Immediate cause of death Carbon Monoxide Poisoning

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 2/25/47Where did injury occur? Oakland Garrett Md
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Private garageMeans of injury Monoxide from auto. Injured at work? NoSigned by Dr. J. Hannon Depts. Med.23. SIGNATURE Dr. J. Hannon M. D. or otherAddress Oakland, Md. Date signed 3/7/47

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MAR 20 1947
BUREAU V S

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Bto*

CERTIFICATE OF DEATH

01717

Reg. Dist. No. 166

1. PLACE OF DEATH:

County Garrett
City or town Mt. Lake Park Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Kiser Nursing Home for Age.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Garrett
City or town Mt. Lake Park Maryland.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Henry Witzgal

3. (b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male

White

WIDOWER

6.(b) Name of husband or wife Unknown

7. Birth date of deceased (mo., day, yr.) April, 20, 1885 (c) If alive, give age years

8. AGE: Years 92 Months Days If less than one day
hrs. min.

9. Birthplace Near Grantsville, Md.
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

FATHER 12. Name Henry Witzgal

13. Birthplace Germany

MOTHER 14. Maiden name Unknown

15. Birthplace Germany

16. Informant W.W. Winterburg

Address Grantsville, Maryland.

17. Burial Date thereof Feb. 5, 1947
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Grantsville Cemetery

Location Grantsville, Maryland.

18. Funeral director W.W. Winterburg

Address Grantsville, Maryland.

19. Feb. 3, 19 47 Julia A. Rowan
(Date rec'd by registrar) Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 3- 1947 19 47 at 3:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 45 19 45 to Feb. 3- 19 47
and that I last saw him alive on February 1- 1947 19 47

Immediate cause of death

Heart Failure

DURATION

10-days

Due to Valvular Lesion for several years
and chronic interstitial Nephritis
Due to arterio sclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Edward E. Rowan M.D. M. D. or other

Address Deer Park Md. Date signed 2-3- 1947

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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FEB 25 1947
BUREAU V.B.

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